UWEM UMOH
ATTORNEY AT LAW
255 LIVINGSTON STREET, 4TH FLOOR,
BROOKLYN, N.Y. 11217

TEL: 718.360.0527 EMAIL: numoh@umohlaw.com FAX: 718.360.1916

BY EMAIL AND HAND

June 15, 2008

Harold Derschowitz, Esq.
Lester Schwab Katz & Dwyer, LLP
120 Broadway
New York, NY 10271

Re: Jordan Mann v. Plus One Fitness et al.
07 CV 5691(RB)

Dear Harold Derschowitz:

This letter in written in response to your May 30, 2008 letter. The numbers below correspond to the responses in your Notice to Produce that you deemed deficient.

1. Plaintiff is not in possession of any communication between herself and any defendant in this action.

2. Bob Welter and plaintiff are the speakers on the CD previously provided to defendants.

4. Plaintiff refers defendants to documents Bates Stamped JM0008 to JM0184.

5. Plaintiff refers defendants to documents Bates Stamped JM0123 to JM0128.

6. Plaintiff is not in possession of any employment contracts between herself and defendants.

7. Plaintiff received treatment as a result of the claims made in her second amended complaint from :

   Retha Buck treated plaintiff through insurance at Plus one. She treated plaintiff from April 2006 to late June 2006 and can be reached at 2115 Millburn Ave Ste.100. Maplewood, NJ 07040. Her work number is 973-761-1242

   Marlene Friedman was seen through Medicaid. June 2007 to August 2007.

Dr. Ann Boris treated plaintiff from August 2007 to September 2007. Plaintiff currently does not have the address of this doctor, but Dr. Boris treated her through Medicaid.

Crystal Huggins, plaintiff's reverend counseled her from June 2006 to February 2008. She can be reached at 212-696-8528.

8. Plaintiff is not in possession of her taxes from 2006 and 2007. Authorizations are enclosed herein. Plaintiff produced copies of her 2005 taxes, Bates Stamped JM 0207.

9. Plaintiff refers defendants to documents Bates Stamped JM 0001- JM0224. Plaintiff reserves the right to supplement this response as she unsure of all the documents she may present at trial.

10. Plaintiff refers defendants to the disk CD produced containing a conversation between herself and Bob Welter.

11. Plaintiff is not in possession of any statement, written or oral, of any party represented in this action.

12. A picture of plaintiff's hair is attached to this email. The picture was taken during the period of plaintiff's employment at Plus one.

Sincerely,

/s
NKEREUWEM UMOH

Cc:

DEBORAH MARTIN NORCROSS
MARTIN NORCROSS, LLC
110 WALL STREET, RCG SUITE 26th FLOOR
NEW YORK, NEW YORK 10004

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

Jordan Mann, Plaintiff, v. Plus One Fitness; Trump World Towers; "Robert" Doe; Jamie MacDonald; Does 1 – 10 inclusive, Defendant(s).	CIVIL ACTION NO. 07-CV-5691 (NRB/DF) BENEFITS RECORDS AUTHORIZATIONS

To: New York State Department of Labor
PO Box 15130
Albany, NY 12212

RE: JORDAN MANN
Case/File Reference No.:

You ate hereby authorized to release and furnish to the law firm of Lester Schwab Katz & Dwyer, LLP, 120 Broadway, New York, New York 10271, c/o Harold Derschowitz, Esq., attorneys of record for Defendants, complete copies of any and all benefit applications, records, doctors' reports, correspondence, notes, memoranda, invoices and all other documents of any nature that identify or in any way relate to the Workers' Compensation Unemployment Insurance Benefit/ Disability Benefits/Social Security/ Welfare and/or other Benefit claim that was filed by or on behalf of JORDAN MANN and any and all benefits paid to JORDAN MANN pursuant to such a benefit claim.

Jordan Mann
JORDAN MANN
Social Security No.: 147-78-1209

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Jordan Mann	10/8/68	147-78-1209
Patient Address		
80 Saint Nicholas Ave, 5A New York, NY 10026		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Retha Buck 2115 Millburn Ave, Ste. 100 Maplewood, NJ 07040

8. Name and address of person(s) or category of person to whom this information will be sent:
Harold Derschowitz, Esq, Lester Schwab Katz & Dwyer LLP

9(a). Specific information to be released:

- ☒ Medical Record from (insert date) April 1, 2006 to (insert date) Present
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- ✓ **Alcohol/Drug Treatment**
- ✓ **Mental Health Information**
- ✓ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☒ At request of individual ☐ Other:	End of Litigation
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: 6/16/08

_____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Jordan Mann	10/8/68	147-78-1209
Patient Address: 80 Saint Nicholas, Apt 5A, New York, NY 10026		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Medicaid New York State Department of Health, 26 Federal Plaza, Rm 3811 NY, NY 10278

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☒ Medical Record from (insert date) 6/2007 to (insert date) Present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

✓ **Alcohol/Drug Treatment**

✓ **Mental Health Information**

✓ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

NEW YORK STATE
BENEFIT
IDENTIFICATION CARD

ID NUMBER
RA30663D

CARD NUMBER
600485 8722 1306 631 03

SEX
F

DOB
10/08/1968

LAST NAME
MANN

FIRST NAME (ALL)
RHONDA

ADDRESS NUMBER
8722 1306 631

03

(Rev. November 2005)

Department of the Treasury
Internal Revenue Service

▶ Do not sign this form unless all applicable lines have been completed.
Read the instructions on page 2.
▶ Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.

OMB No. 1545-0429

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T**, Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return or employer identification number (see instructions)
X Rhonda Mann AKA Jordan Mann	X 147 78 1209
2a If a joint return, enter spouse's name shown on tax return	2b Second social security number if joint tax return
X	X

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.

Harold Derschowitz, Esq.
Lester Schwab Katz & Dwyer, LLP
120 Broadway
New York, NY 10271

Caution: *If a third party requires you to complete Form 4506, do not sign Form 4506 if lines 6 and 7 are blank.*

6 **Tax return requested** (Form 1040, 1120, 941, etc.) and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ 1040

Note. *If the copies must be certified for court or administrative proceedings, check here.* . . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

01/01/2006 01/01/2007

8 Fee. There is a $39 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.**

a	Cost for each return	$ 39.00
b	Number of returns requested on line 7	2
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . ☒

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer.

X Sign Here	▶ Rhonda Mann Signature (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a ( )
	▶ Title (if line 1a above is a corporation, partnership, estate, or trust)		
	▶ Spouse's signature	Date	

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 41721E Form **4506** (Rev. 11-2005)